



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
C/O HOLLOWAY & GUMBERT
3701 KIRBY DRIVE STE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box
#20

MFDR Date Received
JUNE 18, 2007

Respondent Name

DALLAS NATIONAL INSURANCE CO

MFDR Tracking Number

M4-07-6817-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated June 15, 2007: "Texas Orthopedic Hospital billed its usual and customary charges for its services. The total sum billed was \$148,264.94...The claim presented by Texas Orthopedic Hospital was billed in the same manner and at the same rates that it would bill any health plan or insurer... Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...the fees paid by Aspen Administrators on behalf of Dallas National Insurance Company do not conform to the reimbursement section of rule 134.401...it is the position of Texas Orthopedic Hospital that all charges relating to the admission of [Claimant] are due and payable as provided for under Texas law and the Rules of the Division, as currently adopted and published at 28 TAC §134.400 *et seq.*"

Requestor's Supplemental Position Summary Dated June 27, 2007: "Pursuant to DWC Rule 133.307(g)(3), please find enclosed the amended DWC060 Form. It appears that all of the correspondence and supporting documentation submitted to TDI, DWC in our packet dated June 15, 2007, indicated Texas Orthopedic Hospital as the requestor. However, Christus St. Elizabeth Hospital was inadvertently noted on the DWC060 Form, which is not correct. Please make the correction referencing that the correct name of the requestor is: **TEXAS ORTHOPEDIC HOSPITAL.**"

Amount in Dispute: \$15,939.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated June 1, 2007: "The Requesting Party is asserting entitlement to an additional \$15,939.26 in reimbursement based on total charges of \$148,264.94 for an inpatient admission. The Carrier has already paid \$95,259.44 in reimbursement. The Requesting Party incorrectly asserts that Adopted Rule 134.401 (c)6 applies... Thus, to be entitled to the 'Stop Loss Method' of reimbursement the Requesting Party must demonstrate that, in addition to the charges exceeding \$40,000, the services must also be unusually extensive services required during the admission...nothing contained in the medical records establishes that the services provided were unusually extensive as required...nothing submitted by the Requesting Party indicates that services provided were unusual or extensive...no records were submitted with the itemized charges providing any further justification for the submitted charges. Consequently, the reimbursement rate is defaulted to TEXAS ADOPTED RULE 143.401c(3) and the state guidelines for reimbursement."

Response Submitted by: Lewis & Backhaus, PC

Respondent's Position Summary Dated June 18, 2007: "134.401 – does not apply. Reimbursement made under State guidelines."

Response Submitted by: Dallas National Insurance Company

SUMMARY OF FINDINGS

| Disputed Dates | Disputed Services | Amount In Dispute | Amount Due |
|---|-----------------------------|-------------------|------------|
| July 11, 2006 through July 26, 2006 | Inpatient Hospital Services | \$15,939.26 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W1 – Workers Compensation State Fee Schedule Adjustment
- Charge exceeds Fee Schedule allowance
- 222 – Carrier did not define this denial reason code on the EOB.

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges *in*

this case exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection...” 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states “...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, (A) (v) of that same section states “...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed...” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$148,264.94. The Division concludes that the total audited charges exceed \$40,000.
2. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The Third Court of Appeals’ November 13, 2008 opinion states that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services” and further states that “...independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” The requestor in its position statement states that “Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor (‘SLRF’) of 75%.” This statement does not meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C) because the requestor presumes that the disputed services meet Stop-Loss, thereby presuming that the admission was unusually extensive. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).
3. 28 Texas Administrative Code §134.401(c)(6) states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The Third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. The requestor’s position statement does not address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar surgical services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers’ Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” The length of stay was fifteen days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of fifteen days results in an allowable amount of \$16,770.00.
 - 28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).”
 - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$32,577.15.

- The Division finds the total allowable for the implants billed under revenue code 278 is:

| Description of Implant per Itemized Statement | Units | Cost Per Unit | Cost + 10% |
|---|-------|-----------------------------|------------|
| CEMENT SIMPLEX | 6 | No support for cost/invoice | \$0.00 |
| SNI PLT SH 75 6H 10180 | 2 | No support for cost/invoice | \$0.00 |
| SNI ROD THR 120 102303 | 6 | \$9.78 | \$64.55 |
| SNI ROD THR 200 102305 | 3 | \$13.83 | \$45.64 |
| SNI ROD THR 350 102313 | 3 | \$19.11 | \$63.06 |
| SNI HNG MAL HIPRO 1016 | 2 | \$35.70 | \$78.54 |
| SNI RNG FUL 180 710701 | 5 | \$467.34 | \$2,570.37 |
| SNI RNG ½ 180 710701 | 1 | \$424.57 | \$467.03 |
| SNI RNG FT 180L 710701 | 1 | \$509.33 | \$560.26 |
| SNI FIX BOLT CANN 1006 | 4 | No support for cost/invoice | \$0.00 |
| SNI FIX BOLT SLOT 1007 | 24 | No support for cost/invoice | \$0.00 |
| SNI BOLT 10MM 103200 | 20 | \$1.24 | \$27.28 |
| SNI BOLT 16MM 103201 | 4 | \$1.34 | \$5.90 |
| SNI ANCH 2MM 102706 | 2 | \$6.46 | \$14.21 |
| SNI ANCH 4MM 102707 | 5 | \$6.46 | \$35.53 |
| SNI NUT 10MM 103300 | 86 | \$1.34 | \$126.76 |
| SNI NUT 4 PT D/C 10330 | 10 | \$29.65 | \$326.15 |
| SNI SOCKET THR 20 109 | 4 | No support for cost/invoice | \$0.00 |
| SNI SOCKET THR 60 1009 | 3 | \$26.35 | \$86.96 |
| SNI PLT SH 45 3H 10180 | 4 | \$29.18 | \$128.41 |
| SNI WIRE 1.8X370 10210 | 3 | \$23.82 | \$78.61 |
| SNI WIRE OLV 1.8 10210 | 14 | No support for cost/invoice | \$0.00 |
| TOTAL | 212 | | \$4,679.25 |

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that “When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399).” A review of the submitted hospital bill finds that the requestor billed \$878.85 for revenue code 390-Blood/Storage Processing and \$114.75 for revenue code 391-Blood Administration. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 390 and 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(C) states “Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.” A review of the submitted itemized statement finds that the requestor billed \$379.29/unit for Hydromorphone 20MG/100 and \$342.01/unit for Vancomycin 1GM/D5W 200. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is \$21,449.25. The respondent issued payment in the amount of \$95,259.44. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

| | | |
|-----------|--|------------|
| _____ | _____ | 05/01/2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service* demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.